Continuity of Offender Treatment for Substance Use Disorders From Institution to Community

Treatment Improvement Protocol (TIP) Series 30

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What Is a TIP?

Treatment Improvement Protocols (TIPs) are best practice guidelines for the treatment of substance use disorders, provided as a service of the Substance Abuse and Mental Health Service Administration's Center for Substance Abuse Treatment (CSAT). CSAT's Office of Evaluation, Scientific Analysis and Synthesis draws on the experience and knowledge of clinical, research,

and administrative experts to produce the TIPs, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPs is expanding beyond public and private substance use disorder treatment facilities as substance use disorders are increasingly recognized as a major problem.

The TIPs Editorial Advisory Board, a distinguished group of substance use disorder experts and professionals in such related fields as primary care, mental health, and social services, works with the State Alcohol and Drug Abuse Directors to generate topics for the TIPs based on the field's current needs for information and guidance.

After selecting a topic, CSAT invites staff from pertinent Federal agencies and national organizations to a Resource Panel that recommends specific areas of focus as well as resources that should be considered in developing the content of the TIP. Then recommendations are communicated to a Consensus Panel composed of non-Federal experts on the topic who have been nominated by their peers. This Panel participates in a series of discussions; the information and recommendations on which they reach consensus form the foundation of the TIP. The members of each Consensus Panel represent substance use disorder treatment programs, hospitals, community health centers, counseling programs, criminal justice and child welfare agencies, and private practitioners. A Panel Chair (or Co-Chairs) ensures that the guidelines mirror the results of the group's collaboration.

A large and diverse group of experts closely reviews the draft document. Once the changes recommended by these field reviewers have been incorporated, the TIP is prepared for publication, in print and online. The TIPs can be accessed via the Internet on the National Library of Medicine's home page at the URL: http://text.nlm.nih.gov. The move to electronic media also means that the TIPs can be updated more easily so that they continue to provide the field with state-of-the-art information.

Although each TIP strives to include an evidence base for the practices it recommends, CSAT recognizes that the field of substance use disorder treatment is evolving, and research frequently lags behind the innovations pioneered in the field. A major goal of each TIP is to convey "front-line" information quickly but responsibly. For this reason, recommendations proffered in the TIP are attributed to either Panelists' clinical experience or the literature. If there is research to support a particular approach, citations are provided.

This TIP, *Continuity of Offender Treatment for Substance Use Disorders from Institution to Community*, spotlights the important moment in recovery when an offender who has received substance use disorder treatment while incarcerated is released into the community. The TIP provides those who work in the criminal justice system and in community-based treatment programs with guidelines for ensuring continuity of care for the offender client.

Treatment providers must collaborate with parole officers and others who supervise released offenders. The TIP explains how these and other members of a transition team can share records, develop sanctions, and coordinate relapse prevention so that treatment gains made "inside" are not lost.

Offenders generally have more severe and complex treatment needs than many substance use disorder treatment clients, which makes case management an ideal approach. The TIP devotes a chapter to ancillary services such as housing and employment. These needs must be addressed if the client is to remain sober. Finally, the TIP presents treatment guidelines specific to populations such as offenders with mental illness, offenders with long-term medical conditions, and sex offenders. Appendixes include assessment instruments and a sample transition plan. This TIP represents another step by CSAT toward its goal of bringing national leadership to bear in the effort to improve substance use disorder treatment in the United States.

Other TIPs may be ordered by contacting SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI), (800) 729-6686 or (301) 468-2600; TDD (for hearing impaired), (800) 487-4889.

Editorial Advisory Board

Rockville, Maryland

Executive Summary and Recommendations

It is clearly in the public interest for offenders with substance use disorders to receive appropriate treatment both in prison or jail and in the community after release. Numerous studies show that those who remain dependent on substances are much more likely to return to criminal activity. Research also indicates that treatment gains may be lost if treatment is not continued after the offender is released from prison or jail. In part, this is because release presents offenders with a difficult transition from the structured environment of the prison or jail. Many prisoners after release have no place to live, no job, and no family or social supports. They often lack the knowledge and skills to access available resources for adjustment to life on the outside, all factors that significantly increase the risk of relapse and recidivism.

This TIP presents guidelines for ensuring continuity of care as offenders with substance use disorders move from incarceration to the community. The guidelines are for treatment providers in prisons, jails, community corrections, and other institutions, as well as community providers. The following recommendations are based on a combination of research and the clinical experience of the Consensus Panel that developed this TIP. Recommendations based on research are denoted with a (1); those based on experience are followed by a (2). Citations supporting the former appear in Chapters 1 through 6. References to specific programs appear throughout those chapters as well; Appendix B provides contact information for many of those model programs.

Improving Transition to The Community

Much of the responsibility for offenders moving from incarceration to the community lies with community supervision agencies, known in many jurisdictions as parole or postprison supervision. To reach the levels of system collaboration and services integration required, staffs from criminal and juvenile justice supervision and substance use disorder treatment agencies must reach beyond traditional roles and service boundaries by brokering services across systems, sharing information, and facilitating the treatment process. (2)

Overcoming Obstacles to Successful Transitions

Obstacles to successful transition include the fragmented criminal justice system, the lack of attention to offender issues by community treatment providers, disjointed (or nonexistent) funding streams, and the varying lengths of sentences. The following will help overcome those obstacles:

- Fostering criminal and juvenile justice systems integration (for example, CSAT's Juvenile/Criminal Justice Treatment Networks Program)
- Educating and providing incentives for community service providers to meet offender treatment needs
- Integrating funding streams and expanding the funding pool
- Coordinating sentencing practices with treatment goals
- Fostering institution and community agency coordination that promotes continuity of treatment (2)

Case Management and Accountability

Case Management

Case management is the coordination of health and social services for a particular client. When provided to offenders, case management also includes coordination of community supervision. Because case managers work across many agencies to serve their clients, they are sometimes known as *boundary spanners*. See TIP 27, *Comprehensive Case Management for Substance Abuse Treatment* (CSAT, 1998b), for more on case management.

Models for coordinating services for transitioning offenders include institution outreach, community reach-in, and third party coordination, in which a separate entity oversees transition. Though any one is appropriate for different circumstances, the Consensus Panel recommends combined models for optimal transition planning. (2)

Ideally, a single, full-time case manager works in conjunction with a transition team of involved staff members from both systems. However, if the infrastructure and resources do not allow for a full-time case manager position, the treatment provider working with the offender or the supervision officer should take the lead in providing this function. (2)

Need for Assessments

To assist in transition planning, the Panel recommends the use of standardized, comprehensive risk and needs assessment tools appropriate to offender populations. These instruments should be "normed" for various populations, including women and racial and ethnic minorities. (1) The instruments should be in the language of the client.

Assessments for offenders should be conducted within the institution as early and often as possible, and also 3 to 6 months before the offender's release. (2)

Multiple assessments of offenders having substance use disorders are necessary and should examine

- Treatment needs
- Treatment readiness
- Treatment planning
- Treatment progress
- Treatment outcome

Risk and needs assessments are ideally conducted by a multidisciplinary team, with cooperation among all players. Areas to be assessed include skills for daily living, stress management skills, general psychosocial skills, emotional readiness for the transition, literacy, and money management abilities. Criminal justice staff can contribute critical information on risk and dangerousness. Assessment results should follow the offender through the system(s). (2)

Accountability

Violations of any aspect of the transition plan must be dealt with consistently, appropriately, and in a timely manner. (1) Innovative sanctions should be developed to address violations. These sanctions are best given in a graduated manner, with the most severe being a return to prison. (1) The methods used should be understood and agreed upon by both the criminal justice and substance use disorder treatment staffs.

There should be periodic reviews of the issues addressed in the transition plan, including legal matters, appropriate placement in a level of care, the effectiveness of sanctions, and the extent to which the offender is meeting expectations. Correctional and treatment personnel should decrease levels of supervision as the offender takes on more responsibility.

An individualized relapse prevention plan should be developed for each offender. It is often developed as a standard form, written in simple, nonclinical language, with a checklist of behavioral indicators that help predict the potential for relapse. The plan should be **used by all parties:** the offender, treatment agency, supervising officer, and others. (2)

Treatment needs should be reassessed when there are problems (e.g., "dirty" urines, lack of progress in treatment) and, if clinically appropriate, the offender should be moved to a higher or more intensive level of care. (1) The length of stay in the program should be determined by the treatment provider who, along with the community supervision officer, can monitor the progress of the offender.

Guidelines for Institution and Community Programs

Institutions

The term *institution* refers to prisons, jails, and youth detention facilities. Prisons are either Federal or State facilities that usually house offenders for 1 year or more. Prisons represent the end of the adjudication process, whereas jails contain offenders who have not come to trial as well as those with short sentences. Jails are usually run by local governments, though some States, such as Alaska, oversee a jail system. Youth detention facilities provide temporary care and restrictive custody for juvenile offenders (or juveniles alleged to be delinquent). Youth detention can take place pre- or postadjudication, and facilities are usually under local jurisdiction. Regardless of which level of government is responsible for the facility, institution programs should comply with State treatment standards to the extent possible, bringing those programs into a larger context of community-based treatment. To that end, institutional treatment should focus on preparing and motivating the offender for continued care in the community. (1)

Chapter 1 -- Introduction

On any given day, some 1.7 million men and women are incarcerated in Federal and State prisons and local jails in the United States, and a recent study suggests that more than 80 percent of them are involved in substance use. In 1996 alone, taxpayers spent over $30 billion to incarcerate these individuals -- who are the parents of 2.4 million children. Put another way, one of every 144 American adults is behind bars for a crime in which substances are involved (The National Center on Addiction and Substance Abuse at Columbia University [CASA], 1998).

By a variety of measures, it is clear that substance use disorders disproportionately affect incarcerated Americans (Reuter, 1992; CASA, 1998; Federal Bureau of Prisons, 1997). Yet this population is significantly undertreated: Although prison substance use disorder programs annually treat more than 51,000 inmates, this figure represents less than 13 percent of the offender population identified as needing treatment. Studies also indicate that (with the exception of detoxification) most offenders have never received treatment in the community (Lipton et al., 1989; Peyton, 1994). Clearly, the majority of individuals in the criminal justice system in need of substance use disorder treatment are not receiving services -- either while they are incarcerated or after release to the community.

Providing substance use disorder treatment to offenders is good public policy. Recent research shows that punishment is unlikely to change criminal behavior, but substance use disorder treatment that also addresses criminal behavior can reduce recidivism (Andrews, 1994). Inmates with substance use disorders are the most likely to be re-incarcerated -- again and again -- and the length of their sentences continually increases. The more prior convictions an individual has, the more likely he has a substance use disorder. In State prisons, 41 percent of first offenders have used drugs, compared to 63 percent of inmates with two prior convictions and 81 percent of inmates with five or more prior convictions. Half of State parole and probation violators were under the influence of drugs, alcohol, or both when they committed their new offense. State prison inmates with five or more prior convictions are three times more likely than first-time offenders to be regular crack cocaine users (CASA, 1998). Offenders with substance use disorders not only crowd the nation's prisons, they are also responsible for a disproportionate amount of crime and for relatively violent crime. Compared to offenders who do not use drugs, drug-using "violent predators" commit many more robberies, burglaries, and other thefts (Chaiken, 1986).

However, offenders who have completed substance use disorder treatment during incarceration are still at great risk for relapse and recidivism when released. They need a variety of services to maintain sobriety during their transition from the institution to the community. This chapter provides an overview of the benefits of those transitional services. It also discusses obstacles to implementing such services and provides strategies for overcoming these obstacles. Finally, models for transitional services are described.

Benefits of Offender Treatment

Treatment During Incarceration

Some incarcerated offenders enter treatment for the same reasons as those "on the outside": They want to stop using substances and need help. Others, however, may have different motivations: boredom, the desire to improve their chances for parole, a wish to escape the violent culture of general population, or some combination of the above. Others may be mandated to treatment by the courts. Surprisingly, research shows that once an offender begins treatment, outcomes are not affected by the reasons for entering treatment (Leukefeld and Tims, 1988). A certain proportion of those who undergo treatment within the institution will succeed if supervised closely (Anglin and McGlothlin, 1984; Petersilia et al., 1992). Other key findings on the effectiveness of substance use disorder treatment within correctional institutions include the following:

- Prerelease therapeutic communities have shown high rates of success among inmates studied (Wexler et al., 1988; Field, 1989).
- Involvement in substance use disorder treatment is associated with decreased criminal recidivism. Improvements have been seen in rates of rearrest, conviction, reincarceration, and time to recidivate (Field, 1995a; Inciardi, 1996; Peters et al., 1993; Swartz et al., 1996; Wexler et al., 1990).
- Involvement in substance use disorder treatment is associated with decreased substance use and relapse and other health-related outcomes (Inciardi, 1996; Martin et al., 1995; Wexler et al., 1990).
- Duration of correctional substance use disorder treatment is associated with positive treatment outcomes. Research has shown that, up to a point, longer lengths of treatment are more effective than shorter lengths of treatment for substance-using offenders (Swartz et al., 1996; Wexler et al., 1992).
- Involvement in substance use disorder treatment, such as prison-based therapeutic communities, is associated with successful parole outcomes (including reductions in parole revocations) (Field, 1989; Wexler et al., 1992).
- Inmates involved in substance use disorder treatment had reduced rates of re-arrest and relapse when compared with inmates who did not participate (Federal Bureau of Prisons, 1998).

Treatment During Transition To the Community

Service systems should provide offenders with appropriate treatment, since no treatment is likely to lead to continued drug use and crime. Treatment that stops when the offender is released, however, may not be enough. Release presents offenders with a difficult transition from the structured environment of the prison or jail: Despite the hardships endured "inside," they at least knew what to expect. Many offenders are released with no place to live, no job, and without family or social supports. They often lack the knowledge and skills to access available resources for adjustment to life on the outside, all factors that significantly increase the risk of relapse and recidivism (Leshner, 1997). The positive effects of substance use disorder treatment within correctional institutions may diminish once the offender moves out of the institutional environment unless followup care is provided in the community (Martin et al., 1995; Peters et al., 1992; Swartz et al., 1996).

The benefits of treatment during the transition from incarceration to the community are substantiated in several recent studies. In a study of drug offenders in Delaware, offenders who participated in 12 to 15 months of treatment in prison and another 6 months of treatment in the community were more than twice as likely to be drug-free 18 months after release as those who

had only the prison treatment. Those offenders were also arrested much less in the year and a half following release (Inciardi, 1996). A similar study in California had comparable results (Wexler, 1996). Continuity of care from the institution to the community is associated with positive outcomes for prevention of relapse and criminal recidivism in other research as well (Swartz et al., 1996; Wexler et al., 1990).

Chapter 2 -- Case Management and Accountability

Coordinating systems to help the newly released offender can seem overwhelming, due in large part to the burgeoning caseloads carried by public sector agencies. Not only are the criminal justice and substance use disorder treatment systems fragmented and sprawling, but the offender will likely need ancillary services as well (discussed in Chapter 5), which calls for case management. As discussed in Chapter 1, case management can follow an outreach, reach-in, or third-party approach, or some combination of the three. No matter what the model, research shows cost benefits, through reduced recidivism, of cross-system integration for offender transitional services (Inciardi, 1996; Abt Associates, 1995; Swartz et al., 1996).

Case management is the function that links the offender with appropriate resources, tracks progress, reports information to supervisors, and monitors conditions imposed by the supervising agency. These activities take place within the context of an ongoing relationship with the client. The goal of case management is *continuity of treatment*, which, for the offender in transition, can be defined as the ongoing assessment and identification of needs and the provision of treatment without gaps in services or supervision. Accountability is an important element of a transition plan, and case management includes coordinating the use of sanctions among the criminal justice, substance use disorder treatment, and possibly other systems.

Case Management in Transition Planning

Ideally, case management activities should begin in the institution before release and continue without interruption throughout the transition period and into the community. It is recommended that transition planning begin at least 90 days before release from jail or prison. Early initiation of transition planning is important because it establishes a long-term, consistent treatment process from institution to community that increases the likelihood of positive outcomes. The case manager's communication with other transition team members at an early stage supports all aspects of the offender's recovery and rehabilitation (e.g., education, health, vocational training).

Ideal Array of Services

Certain services are integral to a substance-using offender's successful transition to the community. Reassessments should be conducted at various stages throughout the incarceration and community release process. Similarly, offenders also need continued supervision after institution release. Continued supervision also includes ongoing monitoring and assessment of the offender's needs. These periodic substance use disorder and supervision assessments should form the basis for ongoing case management and service delivery. However, additional assistance is needed in a number of areas prior to and after release to prepare the offender for the return to family, employment, and the community.

Often the offender needs help finding housing, since family and social support networks and financial resources may be minimal. Other activities may include teaching basic life skills such as budgeting, using public transportation, seeking and maintaining employment, and parenting. Many offenders have a history of job instability, unemployment, or underemployment. Improving the clients' likelihood of obtaining a job through general equivalency diploma (GED)

preparation, enrollment in an educational program, vocational training, or job-seeking skills class increases their chances of success after release.

Many offenders need training to enhance interpersonal skills in both family relationships and with peers. Training in anger management and in parenting groups can provide new methods for resolving conflicts and facilitating reintegration into the family and community. If possible, the family should be involved in case management and treatment services during the transition to the community. Participation in self-help groups is an important adjunct to substance use disorder treatment to engage the offender in the larger peer support community.

The array of services identified reflects the multiple psychosocial needs of offenders, and takes into account the likelihood that offenders will have periods of backsliding requiring more intensive levels of treatment and supervision.

An effective transition plan is dynamic and evolves as the offender accepts greater responsibility. The offender should be present at team meetings so that she can see accountability modeled as she participates with team members in implementing the plan in the community. Being a part of the planning process helps offenders begin to make their own decisions and take responsibility for themselves. Because of the clear system of sanctions and rewards, a sense of accountability is reinforced.

The Role of the Case Manager

Continuity of care implies that the range of services needed by offenders are received, regardless of the system. When the correctional system and the treatment system collaborate effectively, there is an increased likelihood of treatment success and a reduction in the risk of relapse and future criminal behavior.

Case management is a critical element underlying continuity of care. Studies indicate that case management improves shorter term outcomes of treatment for substance use disorders (Shwartz et al., 1997). The case manager(s) links the offender with necessary resources, tracks progress, reports information to supervisors, and monitors conditions imposed by the court. Systems differ widely in terms of which entity provides case management services, but the necessary functions are the same, whether this role is filled by one person, an interagency team, or a separate agency. The case manager works directly with the client and collaborates with other criminal justice and treatment provider representatives to ensure that the offender maintains abstinence and avoids reoffending.

Case management functions typically include the following activities:

- Assessing an offender's needs and ability to remain substance- and crime-free
- Planning for treatment services and other criminal justice obligations
- Maintaining contact with the probation officer and other criminal justice officials
- Brokering treatment and other services for the offender
- Monitoring and reporting progress to other transition team members

- Providing client support and helping the offender with all involved systems (i.e., treatment, criminal justice, and child welfare)
- Monitoring urinalysis, breath analysis, or other chemical testing for substance use
- Protecting the confidentiality of clients and treatment records consistent with Federal and State regulations regarding right to privacy (42 Code of Federal Regulations [C.F.R.], Part 2)

Staff members of the program Treatment Alternatives for Safe Communities (TASC) begin case management services for the offender as early as local jurisdictions permit -- pretrial, presentence, postadjudication, or prerelease (Weinman, 1992). In a model program in Hillsborough County, Florida, a TASC counselor is assigned to each offender and conducts an intake assessment for the community agency (Department of Justice, 1991). A plan used in Ohio calls for case management activities weeks or even months prior to release, to set the stage for successful reintegration in the community and to develop necessary linkages (Ohio Department of Alcohol and Drug Addiction Services and Ohio Department of Rehabilitation and Correction, 1997).

Chapter 3 -- Guidelines for Institution and Community Programs

Transition plans should be collaborations among providers both inside and outside the institution. For that reason, Chapter 2 outlined the elements of a treatment plan without specifying particular roles for institution and community providers. Although flexibility is key, treatment providers in the community will emphasize different aspects of transition planning. Transition planning also varies from institution to institution and for different types of offenders. This chapter provides guidelines tailored more specifically to providers on both sides of transition.

Reaching Out From the Institution

The focus of institution treatment should be preparation for continued treatment on the outside. The message to the offender is that this is the beginning of the treatment commitment, and that continuing care will be arranged upon release. Institution treatment emphasizes this readiness message in all treatment phases, underlining a strong motivational and relapse prevention message.

Ideally, the institution's treatment program is part of a system that includes community-based services, rather than disconnected from the community. The institution's program should strive to exemplify innovative treatment practices and obtain licensing from the State authority.

Treatment programs within prisons and jails can encourage participation of community programs in the transition process. However, prisons and jails by their nature limit outsiders' access to the institutions, making it a challenge for community-based social service and treatment providers to serve incarcerated people. However, institutions can be community-friendly and invite social service agencies into the institution to work directly with offenders being prepared for release. The community agencies could provide contact information and written literature about services to both staff and inmates. Community treatment providers that contract to deliver institution-based treatment are in an ideal position to also help with transition efforts. Similarly, corrections agencies can enlist contractors to provide case management and other transitional services.

One of the goals of the transition from institutional treatment to community-based treatment is to make better use of institutional treatment as a stepping stone to help offenders become self-sufficient, productive members of society. In the short term, the intent is to help offenders move from an institution-based treatment program to a community-based program with a minimum of

disruption in services.

Special Considerations by Type of Incarceration and Population

Jails

Several differences between prisons and jails affect the way treatment services and transition to the community are delivered. The most significant is length of incarceration. Because jails are used as pretrial facilities for pending court actions, it is often unknown how long an offender will be held, making treatment planning difficult for many jailed offenders. The policy in some States is to provide substance use disorder treatment if the offender is sentenced to jail for 60 days or more.

It is difficult to maintain continuity of treatment in a jail setting, because offenders move in and out of court. Incarceration often creates a crisis that ripples throughout an offender's life, affecting family, legal, and other matters. Children may be placed outside the home, and offenders may be in the process of detoxification. Because jail experiences can cause instability on so many fronts, social service delivery and crisis management are especially important.

The Consensus Panel recommends that treatment be provided if a substance-using offender is scheduled for confinement in jail for a period of time sufficient to provide adequate treatment for the offenders' needs. Inmates with shorter sentences can be placed in alcohol and drug education or other treatment readiness programming. Results from a recent evaluation of the effectiveness of a jail-based treatment program suggested that optimal treatment length is a period of 3 to 5 months followed by immediate placement in a community treatment program (Swartz et al., 1996).

Despite the problems, treatment in jails has some advantages, especially for transition work. The Cook County Jail Day Reporting Center, for example, trains offenders in life skills. More than a dozen social service providers in the community staff the reporting center and conduct trainings on rites of passage, violence prevention, parenting, and relationships. This program also has a training program for offenders who are drug dealers but not drug users.

Jailed offenders often have opportunities to receive substance use disorder assessment and treatment planning from community providers who come into the jail. Assessment or treatment planning that prepares the inmate for more structured treatment on the outside has the benefit of priming the inmate for more intensive treatment in a controlled environment that provides for public safety. Treatment units in jails also have less infractions and violence than other units in the institution.

Furthermore, the sentencing decision may be affected if a local treatment provider involved in the pretrial or presentence phase determines that the offender has demonstrated a willingness to participate in the treatment process and develops a treatment plan. Judges may even consider treatment as an alternative to incarceration. This option provides a strong motivation for many offenders.

A number of studies have shown that treatment effects on recidivism do not appear before about 90 days of treatment, and that treatment effects improve with time in treatment (Hubbard et al., 1989; Simpson, 1981, 1984). Time in treatment, whether in the institution or in the community, is a critical factor. Because jail sentences tend to be short, good jail-to-community continuity of treatment is essential for a longer singular treatment episode. Thus, the Consensus Panel recommends that the shorter the jail program, the more obligation the program has to ensure continuity of service. Even inmates leaving jail without a community sentence should receive a community treatment referral. Likewise, if the offender is sentenced to prison, a treatment plan should follow the offender to the designated correctional institution. If funding is limited, local Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) meetings can be supported in the jail several nights a week. Those incarcerated hear "leads" from previous offenders, find sponsors and mentors, and become less resistant to community-based treatment.

Model Program: Probation Detention Program

Model Program: Probation Detention Program
One potential model for other jurisdictions is found in the Wayne County, Michigan, Comprehensive Corrections Plan funded under the State's Community Corrections Act. The program, called the Probation Detention Program, serves both probation violators who would otherwise be sentenced to jail or prison and graduates of the State's boot camp program, the Sentencing Alternative to Incarceration Program (SAI). This program provides an example of the institution reaching out to a community program to arrange for transitional services. The program is centered at a facility that provides assessment, referral, and residential treatment. Failures are met with "swift and certain" sanctions. Specific services for each offender are determined by an individual risk/needs assessment and implemented by means of a subsequent individualized case management plan. Programming includes 10 areas: orientation and assessment, substance use disorder counseling, life skills counseling, education, employment preparation, vocational training, employment, community service, physical training, and cognitive skill training. The movement of offenders from one phase to another (incarceration to residential programming to community) includes reincarceration when appropriate.

Chapter 4 -- Administrative Guidelines

The development and implementation of transitional programming for offenders requires an effective partnership among diverse criminal justice, substance use disorder treatment, and social services agencies. The designated transitional program administrator must be thoroughly knowledgeable of the obstacles inherent in launching such a collaborative effort. As each agency brings its own culture, agenda, and operational differences to the planning process, administrators from each of the participating agencies must work together to establish compatible goals, policies, and procedures. At the outset of the planning process, the need for individual and organizational flexibility and genuine cooperative effort should be emphasized to all participants.

The role of the administrator of a transitional services program is critical. This individual shoulders the responsibility for managing complex interactions among all agencies and institutions involved in criminal justice accountability and service provision. Therefore, the administrator must be thoroughly familiar with the environments in which participating agencies operate and lead the effort to unify policies so that communications with other organizations and with offenders served are consistent. Knowledge of each agency's administrative environment and procedures improves the likelihood of an effective collaboration.

At the beginning of the planning process, the transitional program administrator and the participating agency representatives should focus attention on several issues that, if left unaddressed, will have a serious impact on the success of offender transitions and the transition program itself. Key issues for consideration are discussed below.

Building an Effective Partnership

Selection of Appropriate Representatives From Each Agency

Ideally, each agency's representative should be a senior staff member who has authority to speak for the agency, make commitments on behalf of the agency, and sign agreements or other official documents. Final sign-off authority is extremely important. The transitional services program administrator should resist any attempts to assign staff members who do not have such authority. However, since partial authority is better than none, accepting representatives who can approve some elements of the transitional program may be necessary if that is the only alternative.

Including other stakeholders (e.g., judges, legislators, advocates) may prove beneficial to the success of the program. For example, if legislators become part of the planning process, they may become advocates for funding. Support at this level can be essential to program implementation and long-term funding.

Knowledge of the Partners and Their Histories

Each participating agency should have a working knowledge of every other participating agency's policies, internal dynamics, service capacities, legal responsibilities, and authority in

relation to the client. This knowledge is essential for the development of mutual respect among the partners. Additionally, familiarity with the organizational history of each agency, including success in collaborative or partnership efforts is important to the planning process. Agencies that have had difficulty sharing authority or yielding control may need to be treated with special sensitivity and attention.

Awareness of Obvious Conflicts in Operations, Policies, and Procedures

Each agency representative should take responsibility for determining how collaboration on transitional services may affect the internal operations of his agency. Coupled with this analysis is the need to make adjustments to ease service planning and program implementation. For example, an agency headed by a board of directors that must approve changes in operations or policy will need extra time to obtain approval.

Recognition of the Partnership as a Hybrid yet Single Entity

The nature of transitional service programs is complex in that several service providers must function as one. Therefore, the organizational goals and culture of each agency must be blended with the others. Differences will exist in professional jargon, organizational structure (including chain of command and identity of the official invested with authority for various programming issues), and the amount of time each agency will need to obtain approval. To mediate these and other differences, the transitional services program administrator can remind the participating agencies that the goals and objectives for each agency and for the partnership are the same.

Education of the Partners

An educational effort may be required to align the partner agencies in an understanding of client characteristics and the diverse agency planning, processes, and programming that may be at play. Agencies that have not worked with offenders will need training on the kinds of issues these clients bring to service providers and on the community concerns that may surface. They will also need to develop an understanding of criminal justice processes and the operating principles that govern community-based organizations and other groups in the partnership, as well as the political forces that shape each agency's agenda. For example, jails and prisons have been under enormous pressures to reduce their populations through the targeting of specific offender populations for diversion. Identification of these target populations will generally include determinations regarding substance use disorder histories. For planners of transition services, this is an important opportunity, as it provides the political motivation to move offenders from jails and prisons into community programs under a carefully designed transition process.

A delicate balance must be reached in order to reconcile differences in policy and procedures among the partnership agencies. Differences left unaddressed at the organizational level can prevent effective service delivery and undermine the program. Figure 4-1 presents a brief developmental scenario of a successful transitional services program.

Policy and Procedural Issues

Administrative Goals and Objectives

During the planning phase of a transitional service program, it is critical to agree on goals that are acceptable to each participating agency. For example, a treatment provider may see a decrease in substance use as a measure of success. The criminal justice agency, however, may believe that abstinence is the only acceptable outcome. Such issues highlight the underlying philosophies of different systems and must be identified and discussed prior to program implementation. Failure to do so may foster interagency mistrust, inmate manipulation, and dishonesty, and can result in program failure. Partnership goals and objectives must also be compatible with any legal conditions placed on an offender by the releasing or supervisory authority.

Treatment Improvement Protocols (TIPs) 17, *Planning for Alcohol and Other Drug Abuse Treatment for Adults in the Criminal Justice System* (CSAT, 1995c), and 12, *Combining Substance Abuse Treatment With Intermediate Sanctions for Adults in the Criminal Justice System* (CSAT, 1994c), describe basic differences in the criminal justice and substance use disorder treatment systems, and the use of sanctions in coordination with substance use disorder treatment.

Interagency Agreements

When possible, the results of negotiating the key components of a transitional services program should be documented in an interagency agreement. All policy and procedural decisions reached during planning meetings should be included in this agreement. Such decisions include

- The development of a shared "vision statement"
- Goals and objectives of transition programming
- Each agency's specific roles, expectations, and responsibilities
- Timing of tasks
- Monitoring procedures
- Shared information requirements
- Client confidentiality
- Program evaluation needs

Chapter 5 -- Ancillary Services

Offenders with substance use disorders need certain basic services as they enter the community. These services are provided by a number of public systems that are generally not well coordinated, and because of the factors discussed throughout this TIP, offenders' abilities to access these services are limited. However, efforts at treatment are unlikely to succeed unless these basic needs are met. Foremost among these needs are

- Housing
- Employment
- Family support
- Peer support
- Transportation
- Education
- Primary health care

Many offenders lack more than one item on this list, and services must be prioritized for each individual. Safe housing is the paramount need for most inmates leaving custody, yet other needs can be almost as pressing for some. For example, transportation to secure housing may be needed, or planning for medication delivery might be crucial to avoid a health or psychological crisis.

Continued recovery requires that substance use disorder treatment remain a high priority during the transition period, but treatment will almost certainly be undermined in importance if any of the supportive components is lacking. Furthermore, public safety is at risk when offenders do not receive necessary supports because they are at greater risk of relapse and a return to criminal activity.

The complexity of accessing services creates many barriers for the offender. The offender must be vested with primary responsibility for meeting her needs, but the stresses of finding housing, employment, and perhaps child care, in addition to requirements for supervision and treatment, increase the potential for relapse. Treatment schedules may conflict with parole mandates, and job-seeking or work may compete for the time allocated for therapeutic needs. Coordination of these supports based on an individualized transition plan helps keep the client from being overwhelmed.

To ensure that each offender has basic needs met when returning to the community, an effective prerelease assessment is essential. The results of the assessment shape the transition plan, and the

transition team has the responsibility to integrate service delivery as much as possible.

The difficulty of coordinating services is not the only roadblock to a successful transition. Some service providers do not consider released offenders their responsibility, particularly if they cannot be easily reimbursed for treatment. Once the offender is no longer within the custody of the criminal justice system, services previously available through that system may be unavailable. This adds to the challenge for case managers or others responsible for brokering care. Returning offenders must often contend with reluctantly given support and a lack of funding for health care and substance use disorder treatment services that were previously received in the correctional institution.

Certainly the offender retains primary responsibility for his own coordination of services, yet the overlap among services and service providers can be confusing and overwhelming. If no entity is required to provide assistance, service providers may "pass the buck," leaving the responsibility for the offender to some other system. Without integration of services, the offender has no access to other systems and is left without resources. This chapter presents the critical elements of a variety of social supports and suggests methods for obtaining services within each system. Relevant examples from model programs or approaches are highlighted throughout.

Housing

It is very difficult for a substance-using offender to make a successful transition to the community without housing that is safe, secure, and free of substances. Upon release, many offenders return to the environments that originally contributed to their drug problems and other criminal activities. Therefore, making sure the offender has suitable housing should be one of the transition team's top priorities. Ideally, substance use disorder treatment is integrated into the housing situation in residential treatment or a halfway house.

Because safe, secure, and drug-free housing is so important -- and often difficult to obtain -- a housing plan should be in place before release from incarceration. The offender, along with the transition team responsible for this service, should identify a living arrangement that meets his needs and then arrange a linkage with the entity providing housing. Local housing agencies can be brought into the team as partners in this effort. Working with publicly subsidized housing, such as Section 8 housing available through the Department of Housing and Urban Development (HUD), can be time-consuming and confusing.

Graduated levels of structured living environments are helpful in easing an offender toward independent living. Community treatment providers can operate supportive living arrangements for offenders engaged in outpatient care. These would be low-cost, substance-free housing environments with a level of peer supervision and support for recovery. Some options are residential treatment facilities, transition treatment centers (such as the Key-Crest program), halfway houses, parole restitution centers, sheltered living situations (such as Oxford House; see box above), and the offender's own home. Special populations, such as mentally impaired or juvenile offenders, may have available housing designed specifically for them.

Model Program: The Center on Addiction and Substance Abuse Demonstration

Program

Model Program: The Center on Addiction and Substance Abuse Demonstration Program
CASA supports a national demonstration program that provides intensive services to offenders who have received significant substance use disorder treatment in an institutional setting and are returning to the community on probation or parole. The goal of the program is to sustain treatment gains and facilitate a "positive reintegration into the community by providing a package of aftercare services." The components of the package can include aftercare treatment, training and employment, substance-free housing, primary and mental health care, and parenting/family skills training. A central tenet of the program is effective case management. An individualized service plan is developed in conjunction with a case manager, and a case management team, housed within the Department of Corrections, is responsible for oversight of the plan. The case manager is the primary point of contact for the offender across all systems involved in the transition plan, including the probation/parole office, the employer, and any contracted third parties. As the individual with the most comprehensive perspective on the offender's needs, the case manager monitors progress and initiates sanctions for noncompliance, alternative referrals if the initial placement is inappropriate, or may recommend re-incarceration for continued infractions. CASA has been evaluating the effectiveness of the program for 3 years through documentation and impact analysis. The outcomes under examination include degree of substance use, involvement in criminal activity and re-arrest, employment status, stability within the community and family, and improvement in general health. Findings will be broadly disseminated for possible replication in other jurisdictions.
Adapted with permission from *Opportunity to Succeed: Post-Incarceration Services for Substance Abusing Offenders Report* published by Columbia University, New York; the Florida Department of Corrections; the Hillsborough County Sheriff's Office, Tampa, Florida; and the Drug Abuse Comprehensive Coordinating Office, Inc., Tampa, Florida.

Chapter 6 -- Special Populations

It is well documented that the most effective substance use disorder treatment is multifaceted and addresses many aspects of the substance user's life. This is particularly true for criminal justice populations, yet treatment providers generally do not match offenders with substance use disorders to services tailored to their needs. Effective care for those with mental and physical health problems, for example, must incorporate the care of these illnesses into the plan for treatment of substance use disorders and criminality. Assessment and treatment efforts must also acknowledge and incorporate the offenders' differences in culture, gender, age, and type of criminal offense.

People with mental and physical health problems constitute a major category of special needs populations. Society's failure to provide appropriate options for them contributes to disproportionately high numbers of these individuals who eventually find themselves under criminal justice supervision -- and many of these offenders, particularly the mentally ill, cycle through the criminal justice and social services systems repeatedly because their problems are not fully addressed in any system. For example, once individuals with mental illness are incarcerated, short-term goals of controlling undesirable behavior and a reliance on medication often take precedence over more comprehensive approaches to treatment.

Upon release, offenders with multiple problems suffer from an additional stigma and may be denied services because community providers lack training to deal with their problems. For example, providers who do not understand the issues for those with mental illness or mental retardation may believe that these individuals cannot benefit from treatment and are dangerous. Part of the case manager's job is to add to the transition team those specialists who can correct such misinformation.

However a population is defined (e.g., by a health problem or cultural background), it is important to know the substances of choice, types of crime, and other life patterns. Elderly people, for example, abuse prescription drugs and alcohol, but rarely use illicit drugs. People with mental retardation are often arrested for nuisance offenses and may be manipulated into criminal activities. Women's substance use is often woven into their intimate relationships; many are incarcerated for possession of a drug that their significant others are selling. These substance use patterns have significant implications for treatment.

Cultural sensitivity and cultural competency, important in all treatment, are particularly essential with offender populations, because minorities are notoriously overrepresented in incarcerated settings. For example, 40.5 percent of the prison population is African-American (Department of Justice, 1998), even though African Americans make up only 12.7 percent of the general U.S. population according to September 1998 census data (U.S. Census Bureau, 1998). For some offenders, such as those of African-American and Latino heritage, the family and extended family should be specifically included in the transition plan because of the importance those cultures place on family relationships. Self-help models of treatment may need adaptation for different cultures and for women.

Ideally, staffing patterns at all levels of the treatment system should reflect the population served, from clerical staff through executive management. Specific efforts should be made to recruit and maintain such staff members. Licensing, certification, and credentialing should support the use of culturally competent staff, and support continuing education in the knowledge and skills relevant to the population. Staff members should be able to communicate in local languages and dialects, and published materials and consent forms should be available in these languages as well. If this is not possible, staff members should find creative means to compensate for this deficit, although family members, especially children, should never be used as interpreters. Incentives that encourage culturally sensitive client interactions should be woven into the employee performance evaluation system.

Whether the differences are cultural, medical, age-, or gender-related, it is important to remember that offenders are not a homogenous population. This chapter will help community treatment providers and correctional workers deliver effective transitional services to groups with special needs.

Women

In 1997, slightly less than 8 percent of those incarcerated were women -- 6.4 percent of the prison population and 10.6 percent of the jail population (Bureau of Justice Statistics, 1998), but that percentage is rising. Women are substantially more likely than men to serve time for a drug offense rather than a violent crime.

Compared to men, women are more heavily drug-involved (Drug Use Forecasting, 1997), and are often polydrug and intravenous drug users, though they use less alcohol than men. Women in prisons in 1996 were most likely to be black (46 percent), ages 25-34 (50 percent), unemployed at the time of arrest (53 percent), and never married (45 percent). In State prisons in 1991 more than 75 percent of the women had children; two-thirds had children under the age of 18 (Bureau of Justice Statistics, 1994).

Incarcerated women and women with substance use disorders are more likely to have suffered physical and sexual abuse (Hein and Scheier, 1996; Miller et al., 1993; CSAT, 1998a). Incarcerated women's physical health profiles include a high incidence of HIV/AIDS and other STDs, pregnancy, and certain types of coexisting mental disorders. The most common mental health disorder among female offenders is depression. At the Turning Point Alcohol and Drug Program for women in Oregon, approximately 50 percent were diagnosed with depression (Edens et al., 1997) (see box). Another commonly found disorder is post traumatic stress disorder, not uncommon in victims of physical and sexual abuse. The importance of addressing women's health care in correctional settings is spelled out by the National Commission on Correctional Health Care's (NCCHC) position statement on Women's Health Care in Correctional Settings. In it, NCCHC recommends, among other things, intake procedures that include gynecologic history and nutritional intake, pregnancy tests, tests for STDs, and available counseling for depression, substance use disorders, and other disorders common to incarcerated women (National Commission on Correctional Health Care, 1994).

Until recent years, substance use disorder treatment programs for women have been slow to emerge in correctional institutions and in the community, and many institutions still have no women-specific treatment services. Those services that are available often evolved from models developed for men.

Incarceration disrupts relationships with children, as well as with a spouse or partner. If a woman is a single parent involved in drugs and criminal behavior, a child protective service agency generally steps in after the arrest to take control and custody of dependent children. A high percentage of mothers have their children permanently removed from their custody as a result of their incarceration. Parental rights for mothers (perceived as chief caretakers) are scrutinized closely by social services and foster care workers. In some jurisdictions, women have been increasingly criminalized for using drugs when pregnant.

Model Program: The Turning Point Alcohol and Drug Program

Model Program: The Turning Point Alcohol and Drug Program
The Turning Point Alcohol and Drug Program at the Columbia River Correctional Institution in Oregon is a 50-bed therapeutic community for women housed in a minimum security State prison. Originally designed to provide only substance use disorder treatment, high program dropout rates due to mental health problems led to the integration of mental health services. About 60 percent of the women in the program are dually diagnosed. Of those, approximately 70 percent have been diagnosed with post traumatic stress disorder, 50 percent with depression, and 15 percent with bipolar disorder. Operated by ASAP Treatment Services, the program is structured in five phases that last from 6 to 15 months during the prerelease period, with an average of 7 to 8 months. Each week, at least 30 hours of treatment and educational services are provided. Group sessions incorporate life skills training, relapse prevention strategies, and substance use disorder education. There are 10 counselors on staff with areas of expertise in assessment, family therapy, mental health counseling, and traditional substance use disorder counseling.

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Appendix B -- Instruments

This appendix includes

- The Substance Use Survey (SUS)
- Adolescent Self Assessment Profile (ASAP)
- Institutional Substance Use Disorder Program Discharge Summary
- Transition Plan from the Powder River Alcohol and Drug Program
- Contacts Directory

Substance Use Survey (SUS)

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Adolescent Self Assessment Profile (ASAP)

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Sample Substance Use Disorder Program Discharge Summary

Discharge Summary

DISCHARGE SUMMARY		
Name	SID #	TDCJ #
Date of Entry	Scheduled Release Date	
County of Conviction	County of Residence	
Primary Counselor		
Transitional Coordinator/Case Manager		
Circumstances of Discharge		

Identified needs and problems (from Master Treatment Plan):
Progress and Prognosis:

Resident	Date
Primary Counselor	Date
Transitional Coordinator/Case Manager	Date
Senior Counselor	Date

What are you going to do if a relapse occurs?
What type of support group(s) will you attend and where?
Will you have a sponsor? Who? Why that person?
Are you going to work the 12 steps?
How are you going to use your leisure time?

PERSONAL AFTERCARE GOALS AND OBJECTIVES

ABSTINENCE GOALS: What do I need to maintain my sobriety? (Basic Needs)

What do I need in order to continue to grow and strengthen my sobriety?

SOCIAL GOALS: What type of relationships with others do I need in order to feel I have a healthy social life that will enhance positive feelings about myself and my sobriety?

PHYSICAL GOALS: What are my specific plans for increasing my physical health?

What type of maintenance schedule will I need in order to continue the changes initiated during my treatment?

RECREATIONAL GOALS: What do I plan to do to meet my needs for fun and frolic that will not endanger my sobriety?

CREATIVE AND OTHER PERSONAL GOALS: In what areas am I creatively talented?

What are some specific projects I want to begin and complete after discharge (e.g., music, art, carpentry, auto mechanics, writing, and electronics)?

What are the steps I need to take in order to successfully initiate and complete a creative project?

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[Tables and Figures]

Figure 1-1: Criminal Justice System Definitions

Figure 1-1
Criminal Justice System Definitions

Many references to community supervision are made throughout this TIP. The following list of general definitions may help a reader who is not familiar with the criminal justice system. However, the definitions may vary slightly from place to place because jurisdictions organize their supervision systems in different ways.

Probation is typically court-ordered supervision imposed in lieu of jail or prison.

Parole is supervision imposed at the end of a jail or prison sentence, perhaps shortening the period of incarceration. As with probation, parole may be revoked, resulting in the individual being incarcerated.

Postprison supervision is used to describe supervision following a completed period of incarceration. Some States have replaced their parole systems with postprison supervision.

Community supervision is the general category that includes all the terms listed above. There are other forms of community supervision as well, such as courts that have their own supervision systems. In this TIP, community supervision is the most commonly used term. A community supervision agent, then, could be a parole officer.

Figure 1-2: Characteristics of Both Outreach and Reach-in Models

Figure 1-2
Characteristics of Both Outreach and Reach-in Models

- Early prerelease planning
- Development of an effective community reentry and relapse prevention plan
- Establishment of linkages among service systems as designated by the plan
- Incorporation of continued community treatment plans as a condition of parole or probation where possible
- Monitoring the offender to ensure that linkages have been made, that transition services are appropriate, and that new issues that have arisen are being addressed
- Establishment of a standard protocol for this function within the system's infrastructure
- Contracted third-party services can fit with either model

Figure 2-1: Indicators of Treatment Success

Figure 2-1
Indicators of Treatment Success

- Reductions in substance use, extended periods of abstinence, substance-free days, crime-free days, reductions in the number of arrests
- Restoration or establishment of ongoing and recovery-supporting social network
- Substance-free and crime-free for at least a year
- Consistent employment
- Stable housing
- Bank account with savings
- Agreed-upon treatment goals met
- Consistent participation in support groups
- Correctional obligations (terms and conditions) met
- Restitution (fines and fees) paid